DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 0 7

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/05

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1902 (V) OF THE ACT

7. FEDERAL BUDGET IMPACT:
a. FFY NONE $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SUPPLEMENT 6 TO ATTACHMENT 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SUPPLEMENT 6 TO ATTACHMENT 2.6-A

10. SUBJECT OF AMENDMENT:
STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Lillian B. Koller

13. TYPED NAME:
LILLIAN B. KOLLER, ESQ.

14. TITLE:
DIRECTOR

15. DATE SUBMITTED: DEC 02 2004

16. RETURN TO:
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
POLICY AND PROGRAM DEVELOPMENT OFFICE
P. O. BOX 700190
KAPOLEI, HI 96709-0190

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: Dec. 7, 2004

18. DATE APPROVED: January 1, 2005

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2005

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State HAWAII

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards
			Gross		Net		
	Federal	State	1 person	Couple	1 person	Couple	Employed
	(1)	(2)	(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X						
- LEVEL I	$579	$521.90	$1,737	N/A	$1,100.90	N/A	
- LEVEL II	$579	$629.90	$1,737	N/A	$1,208.90	N/A	

NOTE: *Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.
**Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit